A Notch Above: Streamlining Capacity Building for M&E in Kenya

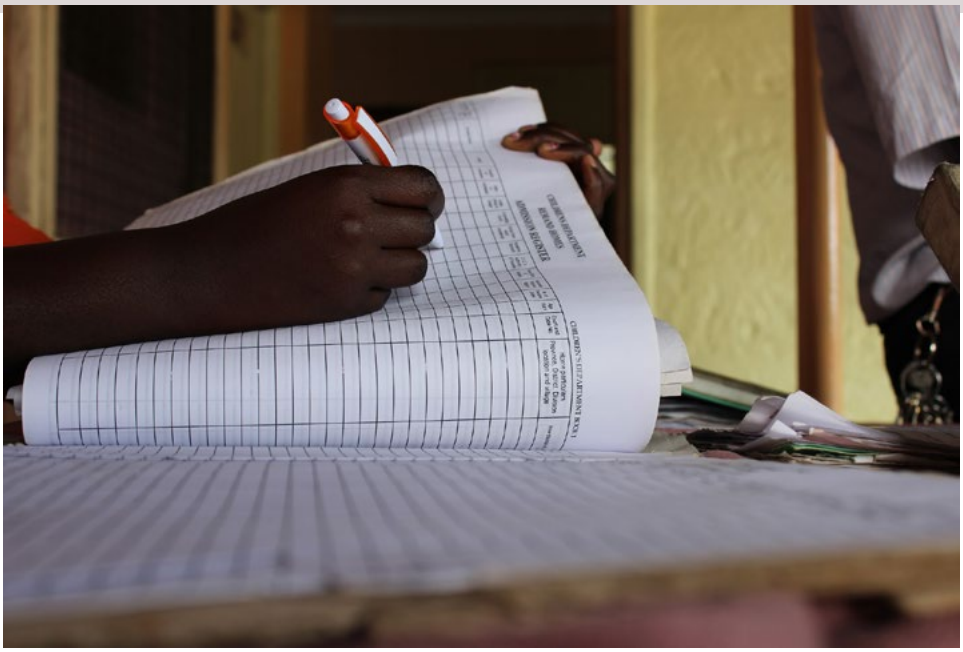


Photo by Yvonne Otieno, MEASURE Evaluation PIMA

Efforts to strengthen the health sector monitoring and evaluation (M&E) system in Kenya have often been frustrated by disjointed activities with no coordination framework. Numerous program-specific and disease-based systems operate independently with no sharing of information. As a result, the information needs of the government and the health sector were rarely satisfied. The country needed to develop a unified approach to strengthening the health sector's capacity to monitor and evaluate performance, by addressing the key components of a functional M&E system.

MEASURE Evaluation PIMA (MEval-PIMA) was funded in 2012 by the United States Agency for International Development (USAID) in Kenya to support the Ministry of Health (MOH) to meet those needs—focusing on strengthening the capacity of health officials at the national and county levels for the M&E of health programs and for making better use of health data for decision making.

The project's first task was to develop a baseline of the current capacity. That assessment revealed several weaknesses in existing M&E systems: the lack of a policy to support M&E activities, no M&E plans in place, a lack of clearly defined roles and responsibilities relating to M&E, the absence of a mechanism to coordinate partners for M&E, no terms of reference (TORs) for the governance of M&E, and no budgets. Some capacities did exist: Counties had annual work plans for M&E activities, but often depended on external funding. Most counties had a database for disease surveillance, but use of the information was limited. County databases were linked to national databases for data aggregation, but these were not interoperable and so were not used for decision making.

To address the situation, MEval-PIMA focused on 17 counties and developed the Monitoring and Evaluation Capacity Assessment Toolkit (MECAT) (see text box). It then conducted assessments in six programs[1] at the national level and 17 counties[2] between 2013 and 2014. The goal was to understand the capacity for M&E among the six national programs and the county health management teams (CHMTs), identify capacity gaps, and devise evidence-informed interventions. The MECAT captured several dimensions of capacity—organizational, technical, and behavioral—and illustrated county capacity using an organizational capacity index (OCI). Across programs and counties, the OCI was generally low, with seven of 17 counties scoring about one-third of 100 percent capacity. The relatively higher scores in the other

1 National Malaria Control Program, Reproductive and Maternal Health Service Unit, Diseases Surveillance and Response Unit, Community Health Services Unit, Civil Registration Service, and the Department of Children Services

2 Kakamega, Bungoma, Garissa, Nakuru, Machakos, Kirinyaga, Kilifi, Kisumu, Nyeri, Siaya, Wajir, Uasin Gishu, Narok, Nairobi, Meru, Mombasa, and Kitui counties.

10 counties were attributed to stronger organizations that had a health strategic plan, dedicated M&E units, and work plans for enacting their strategies. CHMTs reported that they lacked money to undertake data quality audits and had no data use strategies. Evaluation and research scored the lowest: no county had a research agenda and there was no culture of evidence-informed decision making.

With this evidence in hand, the project's strategic approach stressed integration and a systemwide perspective to reduce duplication of effort and to reach all levels of data collectors and users. The baseline assessment provided a powerful and effective platform for preliminary engagement and joint planning with partners. The project used the findings to design stakeholder engagement plans and to prioritize interventions to create more efficient use of resources and a faster-paced implementation process.

As part of the overall strategic approach, MEval-PIMA worked with the M&E Unit at the Division of Health Informatics, Monitoring, Evaluation, and Research at the MOH to develop guidelines, which cover a defined set of common standards for defining M&E, consensus on the characteristics of a functional M&E system and the organizational structures and staffing needed, and governance of coordination forums to support M&E activities.

Specific areas of support were promoting a culture of data use, strengthening governance structures to spearhead M&E activities, and M&E skills building: training on M&E fundamentals and building the capacity of the MOH's senior staff for M&E leadership.

In 2017, MEval-PIMA used MECAT to conduct an end line assessment to detail accomplishments resulting from these activities. The assessment was conducted among the National Malaria Control Programme (NMCP), the Reproductive and Maternal Health Services Unit (RMHSU), and three counties—Kakamega, Siaya, and Narok. Narok was chosen as a control, because MEval-PIMA had not done any capacity building there. Objectives of the end line assessment were to document the following:

- The change in the organizational capacity to undertake M&E
- The key drivers for changes in M&E capacity using participatory approaches, such as most significant change (MSC) and outcome mapping
- MEval-PIMA's contribution to the observed changes in M&E capacity
- Lessons learned in strengthening M&E capacity

The MECAT has contributed to an understanding of M&E capacity and facilitated an effective approach to address capacity issues—with the innovation of having an objective point of view to guide strategy and enable real measurement of effectiveness. The MECAT has provided a systematic means to address capacity.

Specific Contributions of MECAT

The MECAT's contributions to strengthen M&E capacity in Kenya can be applied to other countries. The essential elements are a common language for M&E capacity, a systematic way of measuring progress, and observable change from baseline to end line.

Developing a Common Language on M&E Capacity

The MECAT uses standard definitions of 12 components[3]—later called "capacity areas"—that comprise M&E capacity that an organization might address. For example, one such area—the partnerships and governance capacity area—is broken down into seven discrete elements:

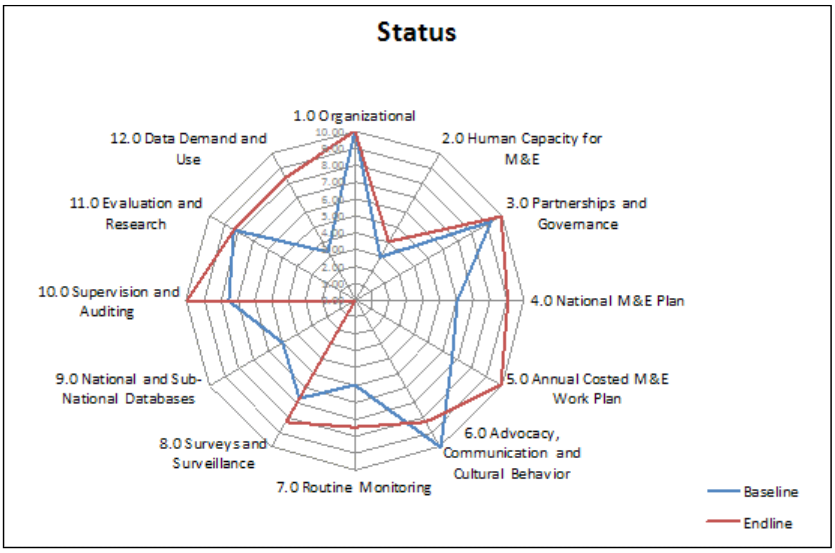
1. Strategy or policy to acknowledge and support M&E performance
2. Standard operating procedures that define roles and responsibilities related to M&E functions and activities
3. An M&E technical working group (TWG)

3 As defined by the Joint United Nations Programme on HIV/AIDS (UNAIDS): www.unaids.org/en/dataanalysis/monitoringandevaluationguidance

4. Commitment from stakeholders for M&E activities and performance
5. An updated inventory of M&E stakeholders for the county or agency
6. Clear mechanisms to communicate M&E activities and decisions
7. M&E unit support of other program functions

Results from the assessment of all capacity areas informed the action plan and capacity-building priorities. As a result, counties and agencies had a roadmap of goals to achieve to strengthen their M&E systems. Counties said the MECAT helped to sensitize them to the pillars that constitute a strong M&E system. In the end line assessment, many participants noted that the baseline was an important factor in helping them identify areas to strengthen, because of its common language for understanding M&E capacity.

Figure 1. Status of capacity areas at the National Malaria Control Programme



Developing a Way of Measuring Progress

Using the 12 defined components of M&E systems strengthening, developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), MEval-PIMA developed a measurement tool that was based on the components but went further—to assess not only if these components existed in a system (status) but also two additional dimensions:

- Quality: This dimension indicates the degree of quality that is met by a specific task or deliverable according to established quality norms.
- Technical autonomy: This dimension rates an organization's internal capacity to accomplish tasks in the 12 M&E capacity areas and financially support these undertakings.

Explaining the Change Observed Between Baseline and End Line

Baseline assessments showed that CHMTs had limited capacity for planning, coordinating, and using health data for planning. Therefore, MEval-PIMA's work with CHMTs focused on improving their capacity to identify and respond to information needs that M&E could use to support service delivery. Based on that baseline, MEval-PIMA chose to intervene in five capacity-building domains:

- **Domain 1: Strengthening structures and mechanisms for M&E coordination.** This domain involved building and supporting M&E processes, policies, guidelines; supporting M&E TWGs; and resource allocation methods. It maps to many elements of the MECAT: organizational capacity, partnerships, governance, a national M&E plan, and an annual costed M&E work plan.
- **Domain 2: Ensuring availability of good-quality data.** Capacity building within this domain focused on developing, improving, and disseminating data collection and reporting tools and providing training on proper coding according to the International Statistical Classification of Diseases (ICD10), strengthening surveillance systems, and supporting a research agenda. This domain maps to many of the elements in the routine monitoring, surveys and surveillance, and supervision and auditing capacity areas of the MECAT group assessment
- **Domain 3: Promoting data use practices.** Work in this domain focused on interventions to improve data use plans, improve data analysis tools, establish a practice of holding data review meetings and other data-sharing forums, and improve information products. This domain maps to elements in the capacity areas of data demand and use and of advocacy, communication, and cultural behavior.

- **Domain 4: Building M&E leadership competencies.** The work here focused on ownership, involvement, partnerships, coordination for M&E, and advocacy for resources to support programs using M&E data. This domain also maps to elements in the advocacy, communication, and cultural behavior and evaluation and research capacity areas.
- **Domain 5: Building M&E capacity of MOH staff.** Here, MEval-PIMA focused on developing training curricula, conducting trainings, mentoring NMCP and county staff, and evaluating programs. This capacity area maps to the M&E area of human capacity.

Observed Changes at the County Level

All three counties assessed at the end line saw improvements from baseline to end line in routine monitoring and supervision, in auditing, and in partnership and governance. The MEval-PIMA intervention counties (Kakamega and Siaya) saw improvements in data demand and use and in the county M&E plans. The control county, Narok, showed no improvements in those areas. The changes in the two intervention counties can be attributed to several factors:

- These counties established an M&E TWG based on their baseline assessment.
- MEval-PIMA work coincided with the national rollout of the DHIS 2 platform; with that came standard data tools and an overall push in data quality. MEval-PIMA advocated the provision of tools and database access to the staff at subnational levels in these two counties (Siaya and Kakamega), which contributed significantly to routine monitoring.
- Sharing of best practices—a driver of data use—improved, because MEval-PIMA supported forums for stakeholders to come together to review data. Without MEval-PIMA's financial support, this might not have happened.
- Both counties (Siaya and Kakamega) also developed a costed M&E work plan.

Observed Changes in the National Health Programs (NMCP and RMHSU)

Both the NMCP and RMHSU improved their structures for coordination and planning—such as TWGs and alignment of their M&E work plans with the national M&E plan. MEval-PIMA supported quarterly review meetings to monitor progress on implementing the annual work plans for both entities. Data use improved for both groups. Technical assistance helped to embed a data use plan for the NMCP and, for RMHSU, MEval-PIMA introduced the reproductive, maternal, newborn, child, and adolescent health (RMNCAH) scorecard as a management tool.

Effects of improvements were better leadership to plan and execute M&E activities and improved human capacity to carry out M&E activities. MEval-PIMA conducted a training of trainers among national staff to build M&E skills so they could then train staff at subnational levels. At RMHSU, the project saw improved capacity to produce information products. Changes at the county level also helped strengthen the M&E systems for these two programs, because the counties report to the national programs.

Photo by Yvonne Otieno, MEASURE Evaluation PIMA

One M&E Framework

The aim of the global Health Data Collaborative (HDC) is to enhance and strengthen Kenya's monitoring and evaluation (M&E) platform for improved measurement of results and accountability in the health sector. The mission aims to strengthen and standardize country measurement and accountability structures to monitor achievement of Sustainable Development Goal (SDG) 3: to ensure healthy lives and promote well-being for all, at all ages. To that end, the collaborative has launched a "One M&E Framework" that is supported by all stakeholders for improving M&E and an accompanying roadmap to show the way.

Kenya is one of five countries selected by the HDC to receive this support. The roadmap is designed to achieve quick wins and tackle short-term priorities through technical working groups that are focused on data analytics, quality of care, a new national health data observatory, civil registration and vital statistics, and health informatics. The national government will provide leadership and coordination of the One M&E Framework and increase allocation of resources towards it. In addition, other actions are planned.

- County governments will use standardized M&E tools and improve data use.
- Partners will align with M&E and move away from program-specific investments in favor of a single M&E framework.
- Faith-based organizations will supply data to national standards.
- Private organizations will foster public-private partnerships for technical assistance in making data systems compatible and improving data architecture, data visualization, and web technologies.
- Civil society organizations will promote data use demand.

Conclusion

MEval-PIMA established a common language and standard definitions, reliable and scientific measures of capacity at baseline and end line, and capacity-building work plans. This solid foundation helped MEval-PIMA address ownership of M&E improvements, build stakeholder buy-in, and demonstrate that important gains can be made with a sustained and rational approach to capacity building.

At the subnational level, a capacity building effort needs to move at the pace unique to each county or health unit, taking its cue from their priorities. For the future, this will require cultivating ownership for M&E among CHMTs, so they can advocate continued support as political leadership shifts over time.

The success of the MECAT is being realized in other contexts. The MECAT has demonstrated the ability to pinpoint capacity status for M&E using a systematic, scientific approach. Its proof of effectiveness to measure progress is a legacy of the MEval-PIMA project's innovative approach. According to Abdinasir Amin, chief of party for MEval-PIMA, "We brought a scientific approach: what is capacity, how do we measure it, how do we know something has changed. Our main contribution has been the metrics, which are cost-effective and easy to see."

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